U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 11 September 2007

In the Matter of
I.C. (WIDOW OF R.C.)
Claimant
v.

KENTUCKY MAY COAL CO.,
Employer

Case No. 2006-BLA-05959

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party-in-Interest

APPEARANCES:
Joseph Wolfe, Esquire
For the Claimant

Lois Kitts, Esquire
For the Employer

BEFORE: DANIEL F. SOLOMON
Administrative Law Judge

DECISION AND ORDER

AWARD OF BENEFITS

This matter arises from a claim for survivor's benefits filed by Ms. I.C., widow of Mr. R.C (miner) for benefits under the Black Lung Benefits Act, Title 30, United States Code, Sections 901 to 945 ("the Act"), as implemented by 20 C.F.R. Parts 718 and 725. Benefits are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis, or to survivors of persons who die due to pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as "black lung" disease.

PROCEDURAL HISTORY

The Claimant's spouse passed away on December 3, 2001. (DX 8). [1] The Claimant filed a survivor's claim on March 14, 2002, which was subsequently awarded in the District Director's Proposed Decision and Order of September 16, 2003. (DX33) The Employer responded by submitting a request for a formal hearing. (DX35) The case was referred to the Office of Administrative Law Judges. A hearing was held on October 26, 2004, in Pikeville, Kentucky, before Judge Thomas Phalen. The Claimant proffered an amended death certificate as evidence to be considered. Counsel for Employer filed a Motion objecting to admission of the amended death certificate. Judge Phalen remanded the case to the District Director for further investigation of the amended death certificate. The initial death certificate had listed myocardial infarction as the immediate cause of death. An amended death certificate changed the immediate cause of death to pneumoconiosis.

The Deputy Coroner, after being compelled to justify the reason for the change, indicated that it was in response to an autopsy performed by a private pathologist hired by the family. The claim was referred back to this office and assigned to me. I held a hearing on March 14, 2007 in Pikeville when testimony of the Claimant was taken, some issues stipulated to, and others withdrawn and no longer being contested. On July 12, 2007, a phone hearing was held between the parties and each side was given 30 days to submit evidence summary forms and briefs.

On August 17, 2007, I received a Joint Stipulation as to Medical Evidence. Along with other medical evidence stipulated to, I admitted the depositions of Dr. Joshua Perper and Dr. Gregory Fino.[2]

Forty Five Director's exhibits, DX 1-DX 45, were admitted into evidence. TR 7.

BURDEN OF PROOF

"Burden of proof," as used in this setting and under the Administrative Procedure Act[3] is that "[e]xcept as otherwise provided by statute, the proponent of a rule or order has the burden of proof." "Burden of proof" means burden of persuasion, not merely burden of production. 5 U.S.C. § 556(d).[4] The drafters of the APA used the term "burden of proof" to mean the burden of persuasion. ***Director, OWCP, Department of labor v. Greenwich Collieries [Ondecko]***, 512 U.S. 267, 18 B.L.R. 2A-1 (1994).[5]

A Claimant has the general burden of establishing entitlement and the initial burden of going forward with the evidence. The obligation is to persuade the trier of fact of the truth of a

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[1] Director's exhibits are marked "DX", Claimant's exhibits are marked "CX" and Employer's are marked "EX". The transcript of the hearing is marked "Tr." I held two separate hearings, the first on March 14, 2007 in Pikeville, KY, and the second a telephone hearing between the parties on July 12, 2007.

[2] *See* Joint Stipulation of Medical Evidence submitted by Employer's Counsel, Ms. Lois Kitts. The Joint Stipulation was sent on August 13, 2007, and received in this office on August 17, 2007.

[3] 33 U.S.C. § 919(d) ("[N]otwithstanding any other provisions of this chapter, ant hearing held under this chapter shall be conducted in accordance with [the APA]; 5 U.S.C. § 554(c)(2). Longshore and Harbors Workers' Compensation Act ("LHWCA") 33 U.S.C. § 901-950, is incorporated by reference into Part C of the Black Lung Act pursuant to 30 U.S.C. § 932(a).

[4] The Tenth and Eleventh Circuits held that the burden of persuasion is greater than the burden of production, ***Alabama By-Products Corp. v. Killingsworth***, 733 F.2d 1511, 6 B.L.R. 2-59 (11th Cir. 1984); ***Kaiser Steel Corp. v. Director***, OWCP [Sainz], 748 F.2d 1426, 7 B.L.R. 2-84 (10th Cir. 1984). These cases arose in the context where an interim presumption is triggered, and the burden of proof shifted from a Claimant to an employer/carrier.

[5] Also known as the risk of non-persuasion, *see* 9 J. Wigmore, Evidence § 2486 (J. Chadbourn rev. 1981).

proposition, not simply the burden of production; the obligation to come forward with evidence to support a claim. Therefore, the Claimant cannot rely on the Director to gather evidence. The Claimant bears the risk of non-persuasion if the evidence is found insufficient to establish a crucial element. ***Oggero v. Director, OWCP***, 7 B.L.R. 1-860 (1985).

APPLICABLE STANDARDS

Because the Claimant filed this application for benefits after March 31, 1980, the regulations set forth at part 718 apply. ***Saginaw Mining Co. v. Ferda***, 879 F.2d 198, 204, 12 B.L.R. 2-376 (6th Cir. 1989). This claim is governed by the law of the United States Court of Appeals for the Sixth Circuit, because the Claimant was last employed in the coal industry in the Commonwealth of Kentucky within the territorial jurisdiction of that court. ***Shupe v. Director,* OWCP**, 12 B.L.R. 1-200 (1989) (en banc).

This case represents a survivor's claim for benefits. In order to receive benefits, the claimant must prove: (1) that the miner had pneumoconiosis, (2) the miner's pneumoconiosis arose out of coal mine employment, and (3) the miner's death was due to pneumoconiosis. 20 C.F.R. § 718.205(a). A miner's death was due to pneumoconiosis if: (1) competent medical evidence establishes that the miner's death was due to pneumoconiosis, (2) pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or the death was caused by complications of pneumoconiosis, or (3) the presumption for complicated pneumoconiosis at § 718.304 is applicable. 20 C.F.R § 718.205(c)(1) – (3). However, survivors are not eligible for benefits where the miner's death was caused by a traumatic injury or the principal cause of death was a medical condition not related to pneumoconiosis, unless the evidence establishes that pneumoconiosis was a substantially contributing cause of death. 20 C.F.R. § 718.205(c)(4).

A "substantially contributing cause" is any condition that hastens the miner's death. 20 C.F.R. § 718.205(c)(5). Any condition that hastens the miner's death is a substantially contributing cause of death for purposes of § 718.205. ***Northern Coal Co. v. Director, OWCP***, 100 F.3d 871 (10th Cir. 1996) (a survivor is entitled to benefits if pneumoconiosis hastened the miner's death "to any degree"); *See also* ***Brown v. Rock Creek Mining Corp***., 996 F.2d 812 (6th Cir. 1993)(J. Batchelder dissenting); ***Island Creek Coal Co. v. Cooley***, 182 F.3d 917(6th Cir., 1999) ; ***Wolf Creek Collieries v. Director, OWCP***, 298 F.3d 511(6th Cir.,2002). Similar to ***Northern Coal***, the Sixth Circuit reaffirmed its holding in ***Brown*** to state that benefits are awarded to a survivor who establishes that "'pneumoconiosis is a substantially contributing cause or factor leading to the miner's death if it serves to hasten that death in any way.'" ***Griffith v. Director, OWCP***, 49 F.3d 184 (6th Cir. 1995); *but see* ***Johnson v. Peabody Coal Co.***, 26 F.3d 618 (6th Cir. 1994) (survivor not awarded benefits where theory of entitlement was that "her husband was severely depressed at the time he committed suicide and that his depression was caused by his illnesses, including pneumoconiosis"). In a survivor's claim filed after January 1, 1982, the evidence must establish that the decedent miner's death was due to pneumoconiosis, and not due to a medical condition unrelated to pneumoconiosis. ***Neeley v. Director, OWCP***, 11 BLR 1-85(1988).

The failure to prove any requisite element precludes a finding of entitlement. ***Anderson v. Valley Camp of Utah, Inc.***, 12 B.L.R. 1-111 (1989); ***Perry v. Director***, OWCP, 9 B.L.R. 1-1 (1986) 1-1 (1986) (en banc). "[T]he presence of evidence favorable to the claimant or even a tie in the proof will not suffice to meet that burden." ***Eastover Mining Co., v. Director, OWCP [Williams]***, 338 F.3d 501, No. 01-4604 (6th Cir. 2003) (citing *Greewich Collieries [Ondecko]*, 512 U.S. 267 at 281).

STIPULATIONS AND WITHDRAWAL OF ISSUES

1. The Employer withdrew its contention that the miner was not a miner under the definition of the Black Lung benefits Act, or that the miner did not have post 1969 employment.[6]
2. The Employer stipulated to at least 20 (twenty) years of coal mine employment.[7]
3. The Employer withdrew several previously contested issues: (1) that Ms. I.C. is the widow of the miner, and (2) that the responsible employer has secured the payment of benefits (insurance).[8]

I have reviewed all of the evidence in the record and I accept the stipulations as they are consistent with the evidence.

ISSUES

1. Whether the miner had pneumoconiosis as defined under the Act.
2. If so, whether the miner's pneumoconiosis arose out of coal mine employment.
3. If so, whether the miner's death was due to pneumoconiosis.

BURDEN OF PROOF

"Burden of proof," as used in this setting and under the Administrative Procedure Act[9] is that "[e]xcept as otherwise provided by statute, the proponent of a rule or order has the burden of proof." "Burden of proof" means burden of persuasion, not merely burden of production. 5 U.S.C. § 556(d).[10] The drafters of the APA used the term "burden of proof" to mean the burden of persuasion. ***Director, OWCP, Department of labor v. Greenwich Collieries [Ondecko]***, 512 U.S. 267, 18 B.L.R. 2A-1 (1994).[11]

A Claimant has the general burden of establishing entitlement and the initial burden of going forward with the evidence. The obligation is to persuade the trier of fact of the truth of a proposition, not simply the burden of production; the obligation to come forward with evidence to support a claim. Therefore, the Claimant cannot rely on the Director to gather evidence. The Claimant bears the risk of non-persuasion if the evidence is found insufficient to establish a crucial element. ***Oggero v. Director, OWCP***, 7 B.L.R. 1-860 (1985).

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[6] *See* TR1 at 17. (TR1 refers to the hearing held in Pikeville, KY on March 14, 2007.)
[7] *Id*. at 17.
[8] *Id* at 6-7.
[9] 33 U.S.C. § 919(d) ("[N]otwithstanding any other provisions of this chapter, ant hearing held under this chapter shall be conducted in accordance with [the APA]; 5 U.S.C. § 554(c)(2). Longshore and Harbors Workers' Compensation Act ("LHWCA") 33 U.S.C. § 901-950, is incorporated by reference into Part C of the Black Lung Act pursuant to 30 U.S.C. § 932(a).
[10] The Tenth and Eleventh Circuits held that the burden of persuasion is greater than the burden of production, ***Alabama By-Products Corp. v. Killingsworth***, 733 F.2d 1511, 6 B.L.R. 2-59 (11th Cir. 1984); ***Kaiser Steel Corp. v. Director***, OWCP [Sainz], 748 F.2d 1426, 7 B.L.R. 2-84 (10th Cir. 1984). These cases arose in the context where an interim presumption is triggered, and the burden of proof shifted from a Claimant to an employer/carrier.
[11] Also known as the risk of non-persuasion, *see* 9 J. Wigmore, Evidence § 2486 (J. Chadbourn rev. 1981).

CLAIMANT'S (WIDOW'S) TESTIMONY OF MARCH 14, 2007

Direct Examination:
The miner was an electrician and a repairman and a few other jobs he had completed prior to getting his last position. The Claimant testified that the miner last worked for Kentucky May. The miner went to work in the mines a short period of time after the miner and the Claimant were married. The miner's widow testified that the miner had thirty two (32) years of experience in the mines. Widow testified that the miner was energetic person early on in his career; that the miner had difficulties in breathing and looked gray when he was exerting himself. The miner had slowed down in being able to work the hours that he wanted to and had been used to. He struggled to accomplish simple everyday tasks. He could not walk very far and he got sick when he exerted himself too much. The Claimant testified that she had not remarried and that all of their children were grown and there were no dependents.

Cross Examination:
The Claimant testified that she had no dependents at the time of the miner's death. She also testified, in response to Counsel's questions, that she was drawing on Federal benefits and not receiving any state benefits. There is a pending state claim.

Redirect Examination:
The Claimant has retained the services of an attorney for her state claims. Mr. Lawrence Webster is the attorney handling the widow's survivor's claim.

MEDICAL EVIDENCE

The following is a summary of the evidence of record:

Autopsy Reports

Date of Autopsy	**Physician/Facility**	**EXH.**
1/3/2002	**Dr. James A. Dennis**	DX11, DX12, DX13

Gross Description:
A section through the apical portion of the left lung shows thick scarring and plaque formation. The dependent portion of the lower lobe shows some black pigment deposition in lymph nodes of the hilum. The lobular architecture of the lung is accentuated by thin fine lines of black pigment deposition. The architecture of the bronchopulmonary segment is identified by and accentuated by the black pigment deposition. No fibrosis is identified and no emphysematous changes are identified either.

Microscopic Description:
Sections of the left lung show dense fibrosis and some calcification and black pigment deposition in association with the fibrosis. Silica particles are identified by polarized microscopy. Black pigment deposition is noted in and about the pleural surface. Section 1F of the right lung shows thickened pleura, atelactasis, and part of a macule on the surface of the lung that measures at least 1cm. Black pigment deposition is present. Section 1H shows a dense nodule of fibrous connective greater than 1.5cm diameter which completely obliterates the hilar lymph node.

Pathological diagnosis:
Black pigment deposition and fibrotic nodule of hilum of right lung. Emphysematous changes. Coronary artery disease moderate to severe.

The patient died as a result of pulmonary illness with severe anthracosilicosis, progressive fibrosis was appreciated, some of the macules present were greater than 1.5cm to 2cm diameter.

Autopsy Slide Review

Date of Review	**Physician/Facility**	**EXH.**
04/28/2004	**Dr. Raphael Caffrey**	DX42-215

Dr. Caffrey reviewed twenty (20) autopsy slides. Microscopic examination of the left lung shows honeycombing of the lungs with cystic spaces and focal fibrosis. Overall there is a mild to moderate amount of anthracotic pigment with reticulin and focal emphysema. Under polarized light there are some bifringement particles consistent with silica. There is definitely no evidence of complicated pneumoconiosis.

Examination of the right lung shows subpleural fibrosis with a moderate amount of anthracotic pigment. Two slides show hilar lymph node tissue with large macronodules 1-3 cm in size with a large amount of collagen and anthracotic pigment but these are within the lymph node tissue. Overall there is moderate amount of anthracotic pigment most notably subpleurally and around blood vessels and respiratory bronchioles. There is definitely no evidence of complicated pneumoconiosis.

Several slides show sections of coronary arteries with severe atherosclerosis with some 70%-90% narrowing of the lumen with atheromatous material.

Dr. Caffrey concluded that there is no evidence of a myocardial infarct on the slides, although it is quite possible that the patient did not live long enough afterwards. Dr. Caffrey disagrees with Dr. Dennis' autopsy interpretation because there is no evidence of complicated pneumoconiosis; there were no lesions 1.5cm to 2cm on the autopsy slides except within the hilar lymph node tissue, and complicated pneumoconiosis must be identified within the lung tissue per se and not within lymph node tissue. Dr. Caffrey also disagrees with the findings of cor pulmonale as he does not see any evidence of vascular changes consistent with cor pulmonale on the autopsy slides.

The miner had simple coal workers' pneumoconiosis but it was minimal because the lesions of simple CWP do not occupy more than five (5%) of the lung tissue.

Death Certificate

Date of Certificate	Physician/Facility	EXH.
12/18/01 (date filed) 3/14/02 (received)	**Jimmy Maggard**	DX8

Immediate cause of death listed as myocardial infarction.

12/18/01 (date filed) 5/30/02 (received)	**Jimmy Maggard**	DX9

An amended death certificate was issued changing the immediate cause of death from myocardial infarction to pneumoconiosis and changing the county where the death occurred from Pike county to Perry county in Kentucky.

Hospitalization Records/Treatment Notes

Date of Exam	Physician/Facility	EXH.
12/3/2001	**Hazard ARH**	DX16

The miner was brought from the mines with full arrest. He had already been shocked multiple times and had received 4mg of atropine. The miner continued to be asystolic and hypotensive. Shortly after arrival the miner was pronounced dead.

7/25/1984 Thru 11/12/1992	**Pikeville Medical Center**	DX15

Assorted treatment records showing clear lungs and no complaints of SOB. On November 12, 1992, miner was seen in hospital complaining of chest pain. Chest x-ray showed no evidence of active disease.

On January 1, 1992 the miner was seen for a 1 inch long laceration of the forearm.

Miner was admitted on July 21, 1988 for acute left ureteral colic, nausea, and vomiting. Patient's x-ray showed a linear atelactasis in the right lobe, but otherwise unremarkable. There are linear densities present in the right lung which were not present in a previous study. There are new linear densities present in the middle lobe which probably represents discoid atelactasis.

On July 25, 1984, the miner was treated for 1st and 2nd degree burns resulting from a switchboard accident. The burns affected the area of the face, arms, chest, and neck.

5/3/1995 Through 5/29/2001	**MCHC (Mountain Comprehensive Health Care)**	DX14

Assorted treatment showing clear lungs and no complaints of SOB.

04/28/95 through 9/25/01	**MCHC (Mountain Comprehensive Health Care)**	DX14

Hospital notes and clinical visits detail the miner's ongoing treatment for cardiac problems. The miner has a family history of heart disease. Father died of sudden cardiac arrest at 63. The miner's medical history includes a heart attack, elevated cholesterol, and various work related injuries, including burns and lacerations.

07/25/84 through 11/17/92	**Pikeville Methodist Hospital**	DX15

Hospitalization notes reveal treatment for chest pains, weakness, nausea. Family history of cardiac problems. Father died at age 63 of sudden cardiac arrest. Examination of the miner reveals evolving inferior wall myocardial infarction likely. History of pneumonia. Treatment notes indicate that a chest x-ray in July 1988 revealed linear densities present in the right lung base.

12/3/01	**Hazard ARH Hospital Terminal Emergency Room Visit**	DX16

The miner was brought from the mines with full arrest and was in aystole when he arrived in the emergency room. He was shocked several times and had already received 4mg of atropine and several ampules of epinephrine. A temporary pacemaker was attempted in an emergency manner.

Medical Reports

Date of Exam	**Physician/Facility**	**EXH.**
05/16/04	**Dr. Joshua Perper**	CX1

Dr. Perper, a forensic pathologist, performed a review of records including the death certificate, autopsy report, and slides, as well as medical records from the miner's various clinical and hospital visits. Dr. Perper also reviewed Dr. Caffrey's deposition testimony.

Complicated coal workers' pneumoconiosis and causally associated with centrilobular emphysema. Coal workers' pneumoconiosis was a result of more than 33 years of occupational exposure as a coal miner to coal dust containing silica, a much more than sufficient exposure period necessary for developing coal workers' pneumoconiosis. Coal workers' pneumoconiosis and the associated centrilobular emphysema were a substantially contributing cause of the miner's death, both directly and indirectly through pulmonary insufficiency and hypoxemia, and through hypoxemia triggering a fatal arrhythmia on the background of coronary artery disease. The miner's symptomatic bronchitis can be explained by the invasive process of the coal workers' pneumoconiosis into the bronchus and lining of the mucosa. There were also areas of solid fibrosis which were consistent with coal workers' pneumoconiosis.

Coal workers' pneumoconiosis and the associated centrilobular emphysema was a substantially contributory cause of the miner's death, both directly and indirectly through pulmonary insufficiency and hypoxemia triggering a fatal arrhythmia on the background of coronary artery disease.

09/14/04 **Dr. Fino** DX42

Dr. Fino is board-certified in internal and pulmonary medicine, and a B-reader of chest x-rays. He performed a review of the medical evidence of record, including: hospital admission records from July 15, 1984 through July 28, 1984, chest x-ray of June 1988, hospital report of July 20-21, 1988, operative record of January 1992, hospital record of November 1992, chest x-ray of December 1999, terminal emergency room visit of December 3, 2001, the death certificate, autopsy reports, and pathology reports. Dr. Fino also testified in deposition regarding his own findings.

Dr. Fino concludes that there appears to be considerable agreement on the diagnosis of simple coal workers' pneumoconiosis. Considering the miner's severe coronary atherosclerosis, this could explain his entire clinical course in the mines and then in the emergency room. Based on what the pathologists have noted there is no evidence to back up or corroborate diagnoses of respiratory insufficiency or complicated coal workers' pneumoconiosis. Dr. Fino believes the most likely cause of death was cardiac arrhythmia due to significant coronary artery disease. There is no evidence the miner had cor pulmonale.

07/24/07 **Dr. Rosenberg** EX1

Lymph node involvement by silico-anthracotic tissue does not constitute any form of coal workers' pneumoconiosis, including progressive massive fibrosis. Despite Dr. Perper's description of "malignant invasion" of the airways by anthracotic lymph nodes, this is something that does not relate to CWP. The miner did not have manifestations of airways disease while alive. In fact, his death related to a coronary event which bore no relationship to past coal mine dust exposure and the presence of an anthracotic lymph node. Furthermore, it would be distinctly uncommon for a chest x-ray to fail to demonstrate the presence of PMF, if indeed it was present pathologically.

07/26/07 **Dr. Fino** EX3

Dr. Fino provided an addendum to the earlier medical report. He reviewed medical reports regarding the miner in 2004. The evidence reviewed consisted of medical record of Dr. Rosenberg on September 13, 2004, copy of deposition transcript of October 6, 2004, deposition transcript of Dr. Rosenberg on March 9, 2007, and the deposition transcript of Dr. Perper on May 21, 2007. Dr.Fino found no evidence of cor pulmonale and can state, with a degree of medical certainty that is was not present.

Deposition

Date of Deposition	Witness	EXH.
07/24/04	**Dr. Rosenberg**	EX2

Direct Examination:
There is no evidence of any impairment from a respiratory standpoint. There is no evidence, clinically, before the autopsy was done, of coal workers' pneumoconiosis. There is no evidence in the x-rays of micronodularity or any evidence of CWP. One can have CWP pathologically and have negative x-rays, but this would most likely be a case of minimal or mild types of CWP. The general rule with minimal CWP is that it would not result in impairment. With regards to the miner's death, obviously he died from coronary artery disease. The miner had a positive stress test in 1995. The only way that CWP could be implicated is if it was causing hypoxia or low oxygen. This miner's death was in no way caused by, related to, or hastened by coal mine dust.

Cross-Examination:
Dr. Rosenberg stated that he did not look at any autopsy slides. Dr. Rosenberg never personally examined the miner. Dr. Rosenberg did not view any of the x-rays. Generally, with progressive massive fibrosis, you get preserved lung function in category A opacities. It is not until you get to category B opacities that you see impairment. It would be very, very rare to have complicated black lung in the absence of positive x-rays.

Redirect Examination:
Negative x-rays are a strong indication of the absence of complicated pneumoconiosis because large opacities, in the size of one to two centimeters will show up on x-rays.

08/07/07	**Dr. Fino**	EX4

Direct Examination:
This is a continuation deposition. Dr. Fino had a chance to review additional medical evidence since the date of his last deposition. Dr. Fino reviewed Dr. Perper's deposition transcript and disagrees with Dr. Perper as to the finding of clinical coal workers' pneumoconiosis. There was no evidence of lung disease prior to this man's demise. There was no diagnosis of any type of lung disease, coal dust related condition, or abnormalities on examination of the lungs. Dr. Fino disagrees with the diagnosis of cor pulmonale because there was no evidence of right heart failure due to lung disease. There is no evidence of lung disease prior to this miner's death. Clinical means making the diagnosis based on information prior to someone's death. 1.5 cm to 2 cm lesions and nodules in lymph nodes would not be a diagnosis of complicated workers' pneumoconiosis because if you have coal dust within lymph nodules that is not the same as coal dust or coal dust nodules in the lungs. Taking everything into evidence, Dr. Fino finds that there is no evidence that his death was caused by or contributed to or hastened by coal dust inhalation.

Cross-Examination:
Dr. Fino never actually examined the miner. Dr. Fino did not have the information as to the number of years miner was employed in the coal mines but assumed a sufficient number to cause a susceptible individual a coal dust related lung condition. In his second report, Dr. Fino came up with 32 years of coal mine employment. Dr. Fino is not a pathologist or a medical examiner.

10/16/04 **Dr. Fino** DX42

Direct Examination:
Dr. Fino reviewed various medical records including: Hospital admission records from 1984, chest x-ray of June 1988, hospital admission report of July 1988, November 1992, and outpatient records from 1995 to 2001. He also reviewed emergency room admission reports when the miner passed away on December 3, 2001, along with the death certificate, and the autopsy reports of Dr. Dennis and Dr. Caffrey. In Dr. Fino's opinion, based on the three pathologists, there was a coal dust related pulmonary impairment. Dr. Fino opined that this miner did not have a totally disabling pulmonary impairment. Dr. Fino also did not think that coal workers' pneumoconiosis caused or hastened the miner's death. There was no sign of impairment prior to the miner's death. The miner suffered a cardiac arrest, which was the cause of his death. He had a heart attack in 1992 and was found to have blockage of his arteries.

Cross-Examination:
Dr. Fino was asked several questions regarding the qualifications of a pathologist and the duties of a pathologist in determining the cause of death. Dr. Fino stated that he had never examined the miner. Dr. Fino was under the impression that the miner had approximately 33 years of coal mine employment. Dr. Fino read Dr. Perper's report.

TIMELINESS

The Employer withdrew its initial assertion that the present claim for Black Lung benefits was untimely. However, timeliness is a jurisdictional matter that can not be waived. 30 U.S.C. § 932(f), provides that "[a]ny claim for benefits by a miner under this section shall be filed within three years after whichever of the following occurs later": (1) a medical determination of total disability due to pneumoconiosis; or (2) March 1, 1978. The Secretary of Labor's implementing regulations at 20 C.F.R. § 725.308 sets forth in part, as follows:

(a) A claim for benefits filed under this part by, or on behalf of, a miner shall be filed within three years after a medical determination of total disability due to pneumoconiosis which has been communicated to the miner or a person responsible for the care of the miner, or within three years after the date of enactment of the Black Lung Benefits Act of 1977, whichever is later. There is no time limit on the filing of a claim by the survivor of a miner.

(c) There shall be a rebuttable presumption that every claim for benefits is timely filed. However, except as provided in paragraph (b) of this section, the time limits in this section are mandatory and may not be waived or tolled except upon a showing of extraordinary circumstances.

It is presumed that a claim is timely filed unless the party opposing entitlement demonstrates it is untimely and there are no "extraordinary circumstances" under which the limitation period should be tolled. *See* ***Dougherty v. Johns Creek Elkhorn Coal Corp.***, 18 B.L.R. 1-95 (1994).

In the absence of contrary evidence, I find that the present claim for Black Lung Benefits under the Act was timely filed.

DISCUSSION

EXISTENCE OF PNEUMOCONIOSIS

Pneumoconiosis is defined as a chronic dust disease arising out of coal mine employment.[12] The regulatory definitions include both clinical (medical) pneumoconiosis, defined as diseases recognized by the medical community as pneumoconiosis, and legal pneumoconiosis, defined as any chronic lung disease. . .arising out of coal mine employment.[13] The regulation further indicates that a lung disease arising out of coal mine employment includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment." 20 C.F.R. § 718.201(b). As several courts have noted, the legal definition of pneumoconiosis is much broader than medical pneumoconiosis. ***Kline v. Director, OWCP***, 877 F.2d 1175 (3d Cir. 1989).

A miner can demonstrate the presence of pneumoconiosis by: (1) chest x-rays interpreted as positive for the disease (§ 718.202(a)(1)); or (2) a biopsy report or autopsy report (§ 718.202(a)(2)); or the presumptions described in Sections 718.304, 718.305, or 718.306, if found to be applicable; or (4) a reasoned medical opinion which concluded the disease is present, if the opinion is based on objective medical evidence such as blood-gas studies, pulmonary function tests, physical examinations, and medical and work histories. (§ 718.202(a)(4)).

The evidence under consideration in this survivor's claim does not include any x-rays, pulmonary functions tests or arterial blood-gas studies. The evidence designated for evaluation is limited to medical reports, depositions, hospital treatment notes, clinical visits, autopsy reports, pathology reports, and the death certificate.

X-ray Evidence

Neither party has designated x-ray evidence for consideration in this claim for survivor's benefits.

Autopsy Reports

Following the miner's death on December 3, 2001, an autopsy was performed and autopsy slides reviewed by several physicians. The autopsy report, prepared by Dr. James Dennis on January 3, 2002, included a gross description and a microscopic description.

Dr. Dennis found black pigment deposition in the lymph node of the hilum, as well as in the bronchiopulmonary segment. No fibrosis was identified and no emphysematous changes noted. The microscopic examination of sections of the left lung did reveal some fibrosis and black pigment deposition. Silica particles were evident and macules greater than 1cm were seen in sections of the right lung.

Dr. Caffrey reviewed twenty (20) autopsy slides and found focal fibrosis, and moderate to mild amount of anthracotic pigment with focal emphysema. The right lung revealed subpleural fibrosis with a moderate amount of anthracotic pigment. Two segments showed hilar lymph node tissue with large macronodules 1-3 cm in size. The large lesions and nodules are restricted to the hilar lymph node. Dr. Caffrey concluded that there is no evidence of complicated pneumoconiosis. Dr. Caffrey also indicated that there is no evidence of a myocardial infarct although the miner did not live long enough afterwards. Complicated pneumoconiosis can be ruled out, according to Dr. Caffrey, because all of the lesions greater than 1cm are located within

[12] 20 C.F.R § 718.201(a).

[13] 20 C.F.R. § 718.201(a)(1) and (2) (emphasis added).

the hilar lymph node. The miner did have simple pneumoconiosis but it was minimal because the lesions of simple coal workers' pneumoconiosis did not occupy more than 5% of the lung tissue.

Neither doctor disputes the presence of simple coal workers' pneumoconiosis. Dr. Caffrey concludes that the miner had simple coal workers' pneumoconiosis but qualifies his finding by adding that the impairment was mild or minimal due to the substantially small percentage of the lung where lesions were found. On microscopic examination, Dr. Dennis found anthracotic pigment, and deposits of black pigmentation with associated fibrosis. A diagnosis of anthracosis on autopsy falls within the definition of pneumoconiosis at 20 C.F.R. §718.201(a)(1) (2001). ***Hapney v. Peabody Coal Co.***, 22 B.L.R. 1-106 (2001)(en banc)

There are conflicting opinions between Dr. Caffrey and Dr. Dennis as to whether clinical data demonstrates the presence of complicated pneumoconiosis. Both Dr. Caffrey and Dr. Dennis found lesions greater than 1cm. Dr. Caffrey disputes Dr. Dennis' conclusion as to the presence of complicated pneumoconiosis because the lesions and macules Dr. Caffrey found were all restricted to the hilar lymph node; an area outside of the respiratory system, according to Dr. Caffrey. On microscopic examination, Dr. Dennis found dense fibrosis and black pigment deposition in the left lung, along with Silica particles. Black pigment deposition was also noted in and about the pleural surface. The right lung showed a macule on the surface of the lung that measured at least 1cm. One of the sections of the lung shows a dense nodule of fibrous connective greater than 1.5cm diameter which completely obliterates the hilar lymph node.

Dr. Caffrey argues that Dr. Dennis' findings of large macules, black pigmentation, and fibrosis in the hilar lymph node is not relevant to the issue of pneumoconiosis because the hilar lymph node is not in the lungs. Dr. Caffrey's assertion is incorrect and confuses the location of the lymph node referenced by Dr. Dennis.

Existence of lesions of at least 1cm and greater is accepted by both doctors. Dr. Caffrey's reluctance to find complicated pneumoconiosis appears to be based on the location of the large lesions. Dr. Caffrey does not dispute the size of the lesions that may constitute complicated pneumoconiosis, he asserts that the location within the hilar lymph node does not constitute an area within the respiratory system. In the absence of additional evidence, I find that Dr. Caffrey's opinion as to the exclusion of the hilar lymph node from the respiratory system is unwarranted, and therefore, the existence of complicated pneumoconiosis has been established.

Medical Reports

20 C.F.R. § 718.202(a)(4) sets forth:

> A determination of the existence of pneumoconiosis may also be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in Section 718.201. Any such finding shall be based on objective medical evidence such as blood-gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

Although I find that complicated pneumoconiosis has been established based on the autopsy reports, the record contains the medical reports of Drs. Perper, Rosenberg, and Fino. Dr Fino's initial medical report considers various x-rays not designated for consideration and, therefore, outside the scope of permissible evidence. Realizing the error in considering impermissible evidence used in reaching a conclusion as to pneumoconiosis, Dr. Fino supplies

an addendum to his prior report, this time considering only admissible evidence and reaching the same conclusion as before – that there is no evidence of complicated pneumoconiosis. Dr. Fino does concede that a diagnosis of simple coal workers' pneumoconiosis is demonstrated by the facts in the case. Nevertheless, Dr. Fino also concludes that the miner did not exhibit any respiratory insufficiency, presumptively implying that simple coal workers' pneumoconiosis is mild and not capable of causing respiratory insufficiency.

Dr. Perper finds complicated pneumoconiosis based on the size of the lesions. He concludes that the duration of employment was sufficient time period for the miner to develop pneumoconiosis and states that the miner's death was hastened by coal workers' pneumoconiosis.

Finally, Dr. Rosenberg opines that anthracotic lymph nodes is something that does not relate to CWP. The miner did not have manifestations of airways disease while alive, but his death related to a coronary event which bore no relationship to past coal mine dust exposure and the presence of an anthracotic lymph node. He also states that it is distinctly uncommon for progressive massive fibrosis to be present absent any evidence on the x-rays.

In deposition, both Dr. Fino and Dr. Rosenberg specifically state that there was no evidence of clinical pneumoconiosis prior to the miner's death. By implication, the statements attribute additional significance and weight to evidence obtained during the miner's lifetime over evidence derived as a result of autopsy and pathological examination. I see no basis for such a distinction. Autopsy reports are most probative on the issue of pneumoconiosis. Dr. Rosenberg concedes that CWP may be present in the absence of positive x-rays, but the diagnosis would be that of simple or mild pneumoconiosis; the type unlikely to result in a pulmonary deficiency.

The distinction between complicated and simple pneumoconiosis is based on the size of the nodules or lesions found in the respiratory system and relevant on the issue of pneumoconiosis. The degree of pulmonary impairment; however, is not relevant in establishing the presence of pneumoconiosis. The Claimant has successfully established the presence of pneumoconiosis whether the evidence demonstrates very mild forms of coal workers' pneumoconiosis with no associated functional impairment or whether the evidence demonstrates massive progressive fibrosis with significantly large lesions or nodules.

I give little weight to Dr. Rosenberg's opinion because he did not review much of the evidence he relies on to form his opinion and conclusion. Both Dr. Fino and Dr. Perper reach the same conclusion as to the presence of simple pneumoconiosis; it is complicated pneumoconiosis on which they differ. In addition, the autopsy report, pathology report, and depositions of the physicians rendering medical opinions all confirm the presence of simple pneumoconiosis. Likewise, Dr. Dennis, Dr. Caffrey, and Dr. Perper all agree as to the existence of clinical pneumoconiosis. Dr. Caffrey finds subpleural fibrosis with a moderate amount of anthracotic pigment.

In addition, there are numerous hospital treatment notes which chronicle the miner's continuous bouts with symptoms and complications of cardiovascular disease and its associated treatments. Many of the notes indicate clear lungs on examination. There is substantial medical evidence to indicate that the miner suffered from heart disease and was treated on numerous occasions for complications related to the disease. The primary purpose for the clinical visits and hospital admissions was the miner's cardiovascular disease. X-rays and examinations of the lung were incidental, secondary, and in support of the physicians' procedures in diagnosing and treating the miner's condition for heart disease. There is no evidence indicating the qualifications of those physicians interpreting x-rays and many of the treatment notes

significantly predate, by as much as fifteen years, more recent evidence demonstrating densities on x-rays, lesions on autopsy reports and pathology reports, and medical reports and depositions confirming these findings.

Furthermore, it is an incorrect to infer from the hospital notes that the frequent visits and significant treatments for the miner's heart condition exclude the presence of respiratory or pulmonary disease or impairments. No one disputes the existence of cardiovascular disease, and some of the Employer's physicians concede the presence of a pulmonary or respiratory impairment. Both can co-exist as chronic diseases. It is false to assume that the presence of one necessarily excludes the existence of the other.

I find that there is ample evidence from the medical reports that the miner suffered from clinical pneumoconiosis. While I attribute appropriate weight to the medical reports, I find the pathology reports to be the most probative on the issue of establishing pneumoconiosis. Pathology evidence is the most reliable evidence of the existence of pneumoconiosis. *See* ***Terlip v. Director, OWCP***, 8 B.L.R. 1-363 (1985). (wherein the Board held that an ALJ's deference to autopsy evidence over X-ray evidence was reasonable because "autopsy evidence is the most reliable evidence of the existence of pneumoconiosis.)

Complicated Pneumoconiosis

There a conflict among the Employer's physicians and the Claimant's physicians on the issue of complicated pneumoconiosis. Dr. Dennis performed the autopsy and Dr. Caffrey reviewed autopsy slides. Both Doctors agree on the presence of macules greater than 1 centimeter. Both Doctors agree on the location of the macules: the hilar lymph node. However, each Doctor reaches a different conclusion. The difference of opinion arises due to Dr. Caffrey's assertion that the hilar lymph node is not within the respiratory system and; therefore, lesions found outside the respiratory system do not constitute CWP. Anthracosis is encompassed within the definition of pneumoconiosis at 20 C.F.R. § 727.202. Whether anthracosis of the hilar lymph nodes is pneumoconiosis is a finding of fact to be made by the administrative law judge based on the evidence before him.

I find Dr. Caffrey's assertion to be inaccurate based on the accepted definition of the hilar lymph node and prior Board Decision on this issue. The hilar lymph node is a bronchiopulmonary lymph node consisting of lymph nodes in the hilum of the lung that receive lymph from the pulmonary nodes, and drain to the tracheobronchial nodes. As a part of the pulmonary system, impairment within the hilar lymph node is considered a pulmonary impairment.[14] In ***Taylor v. Director, OWCP***, BRB No. 01-0837 BLA (July 30, 2002) (Unpublished), the Board held that "anthracosis found in lymph nodes may be sufficient to establish the existence of pneumoconiosis."

Earlier I had discounted the weight I attribute to Dr. Rosenberg's opinion on the issue of clinical pneumoconiosis. Dr. Rosenberg, although having never viewed the x-rays, states that negative x-rays are a strong indication of the absence of complicated pneumoconiosis. Apart from the impermissible reference to evidence outside the scope of this case, Dr. Rosenberg's opinion is contrary to some of the provisions of the Black Lung Benefits Act. In ***Gray v. SLC Coal Co.***, 176 F.3d 382 (6th Cir. 1999), the Court held that a diagnosis of the disease may be made based upon chest x-ray evidence revealing opacities which are greater than one centimeter in diameter ***or*** autopsy or biopsy evidence which demonstrates "massive lesions."

[14] *See* Stedman's Medical Dictionary (28th ed. 2005), available at http://www.stedmans.com/section.cfm/45 (last visited Sept. 5, 2007)

Therefore, I accept the factual findings by both Doctor Dennis and Dr. Caffrey, as to the composition and size of the large lesions within the hilar lymph node. I further find that this amounts to a finding of complicated pneumoconiosis.

Furthermore, Dr. Perper, a forensic pathologist, performed a review of the miner's records, including the death certificate and the autopsy report. Dr. Gregory Fino, board-certified in pulmonary and Internal medicine, also reviewed the miner's medical evidence. Both Doctors are in agreement on the issue of simple coal workers' pneumoconiosis, but differ as to the presence of complicated pneumoconiosis. Dr. Fino asserts that there is no evidence to corroborate or backup a diagnosis of complicated pneumoconiosis.

The disagreement among Dr. Perper and Dr. Fino relates to the presence of complicated pneumoconiosis. In determining the weight that I attribute to each Doctor's conclusions, I note that the qualifications of the physicians are relevant in assessing the respective probative values to which their opinions are entitled. ***Burns v. Director, OWCP***, 7 B.L.R. 1-597 (1984). No physician making a diagnosis of complicated pneumoconiosis relies on clinical evidence arising during the miner's lifetime and designated for evaluation in this claim. In fact, no x-rays, pulmonary function tests, or arterial blood-gas studies have been submitted for consideration. The hospital treatment notes reference clinical data obtained as part of the examination during the miner's admission or visit, but little else exists. The findings substantially rely on the autopsy and pathology reports, as well as the medical reports that interpret this data.

I conclude that Dr. Perper's findings are better supported by the evidence in the record and his opinion as to the presence of complicated pneumoconiosis merits more weight than Dr. Fino's.

The diagnosis of complicated pneumoconiosis stems from the findings made on the autopsy and the pathological examination of the lung tissue. Dr. Perper is a forensic pathologist who is better qualified to interpret the medical evidence derived from an autopsy. Dr. Perper is a forensic pathologist better qualified to render an opinion concerning the autopsy and pathology of the lung tissue, than Dr. Fino who is board-certified in pulmonary and internal medicine.

Additionally, Dr. Fino reviewed the findings of others and rendered an opinion as to the presence of complicated pneumoconiosis. There is no indication that Dr. Fino disagreed with the factual findings of the pathologists or prosector. Dr. Fino's opinion report does not take issue with the findings of anthracotic pigment and associated fibrosis within the hilar lymph node. Dr. Fino agrees with the conclusion that this does not amount to a finding of complicated pneumoconiosis. I accord little weight to Dr. Fino's conclusion regarding the presence of complicated pneumoconiosis. Dr. Fino's finding of no complicated pneumoconiosis is not based on an independent assessment and analysis of the clinical evidence, obtained post-mortem; it is merely a reiteration of prior opinions reaching the conclusion that complicated pneumoconiosis does not exist. Thus, it is repetitive and of little probative value on the issue of complicated pneumoconiosis.

I find Dr. Dennis' and Dr. Perper's findings sufficient in establishing complicated pneumoconiosis.

Causation: Pneumoconiosis Arising Out of Coal Mine Employment

If a miner who is suffering from pneumoconiosis was employed for ten years or more in one or more of the coal mines, there is a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 C.F.R § 718.203 (b) (2001). Under the applicable standard in which

this case arises (6th Circuit), the presumption establishes that the miner's pneumoconiosis arose "in part" from his coal mine employment. *See* ***Southard v. Director, OWCP***, 732 F.2d 66, 6 B.L.R. 2-26 (6th Cir. 1984).

The Employer stipulated to at least twenty (20) years of coal mine employment. By operation of law, it is presumed that the miner's pneumoconiosis arose "in part" from coal mine employment.

In reviewing the medical reports and autopsy analysis submitted by the Employer, I find that the Employer has failed to rebut the presumption that pneumoconiosis arose "in part" from coal mine employment. Dr. Rosenberg did not find pneumoconiosis of any kind. I discount the opinion of Dr. Rosenberg as it is contrary to my finding of pneumoconiosis. In ***Skukan v. Consolidation Coal Co***., 993 F.2d 1228, 1233 (6th Cir. 1993), this court stated that an ALJ should treat as less significant physicians' conclusions about causation when they find no pneumoconiosis. Dr. Caffrey examined the autopsy slides and discussed his findings of moderate amounts of anthracotic pigment restricted to specific locations plus the associated evidence of fibrosis. Dr. Fino acknowledged the consensus, among most physicians, as to the presence of simple pneumoconiosis. However, neither of these Doctors specifically addresses the issue of causation. The medical opinions and depositions submitted for consideration in this survivor's claim simply omit discussion of the issue of the etiology of pneumoconiosis. The reports and depositions are framed to address the issue of death due to pneumoconiosis and the presence of pneumoconiosis itself, including complicated pneumoconiosis. When a party establishes a rebuttable presumption on an issue, the burden shifts to the opposing party to rebut the presumption. The burden is on the Employer to rebut the presumption that pneumoconiosis arose, in part, from coal mine dust. The Employer has failed to meet this burden.

Death Due to Pneumoconiosis

Section 718.205 provides that benefits are available to eligible survivors of a miner whose death was due to pneumoconiosis. An eligible survivor will be entitled to benefits if any of the following criteria are met:

1. Where competent medical evidence establishes that the miner's death was due to pneumoconiosis;
2. Where pneumoconiosis was a substantially contributing cause or factor leading to the miner's death, or where death was caused by complications of pneumoconiosis; or
3. Where the presumption set forth in §718.304 (evidence of complicated pneumoconiosis) is applicable. 20 C.F.R. § 718.205(c). Pneumoconiosis is a substantially contributing cause of a miner's death if it hastens the miner's death. 20 C.F.R. §718.205(c)(5).

The circuit courts developed the "hastening death" standard, which requires establishment of a lesser causal nexus between pneumoconiosis and the miner's death.

I have found that the Claimant has successfully established the presence coal workers' pneumoconiosis and complicated pneumoconiosis. I concluded that the autopsy report and autopsy slide review demonstrated the presence of complicated pneumoconiosis. Therefore, the presumption set forth under §718.304(b) is applicable and there exists an irrebuttable presumption of death due to pneumoconiosis.

In the alternative, I find that clinical pneumoconiosis hastened the miner's death.

The United States Court of Appeals for the Third Circuit has held that any condition that hastens the miner's death is a substantially contributing cause of death for purposes of §718.205. ***Lukosevicz v. Director, OWCP***, 888 F.2d 1001 (3rd Cir. 1989). The Fourth Circuit has adopted this position in ***Shuff v. Cedar Coal Co.***, 967 F.2d 977 (4th Cir. 1992), cert. denied, 113 S. Ct. 969 (1993) The Sixth Circuit has found the interpretations of the sister circuits well-reasoned, and the standard, first articulated in ***Lukosevicz v. Director, OWCP***, 888 F.2d 1001 (3d Cir. 1989) and subsequently in ***Shuff v. Cedar Coal Co.***, 967 F.2d 977 (4th Cir. 1992) *cert. denied* 506 U.S. 1050, 113 (1993), has been adopted by the Sixth Circuit. The appropriate standard by this circuit is that this disease will be found to be a "substantially contributing cause or factor" of a miner's death in a case in which it has actually hastened his death. A substantially contributing cause is one that actually hastens the miner's death.

A death certificate was issued and signed by Jimmy Maggard on December 18, 2001. The immediate cause of death was stated to be myocardial infarction. Subsequently, an amended certificate was issued, this time listing pneumoconiosis as the cause of death.[15]

It should be noted that a death certificate, in and of itself, is an unreliable report of the miner's condition and it is error for an administrative law judge to accept conclusions contained in such a certificate where the record provides no identification that the individual signing the death certificate possessed any relevant qualifications or personal knowledge of the miner from which to assess the cause of death. ***Smith v. Camco Mining, Inc.***, 13 B.L.R. 1-17 (1989); ***Addison v. Director, OWCP***, 11 B.L.R. 1-68 (1988). The record under consideration does not address the reasons for the Coroner's sudden reversal of opinion on the causation of death. Without further explanation, I cannot consider this death certificate as having much probative value.

Dr. Fino opines that the *most likely* cause of death is cardiac arrhythmia. Dr. Rosenberg does not add much to Dr. Fino's assessment of the miner. Dr. Rosenberg does not find a correlation or association between the miner's clinical pneumoconiosis and the immediate cause of death. Drs. Caffrey and Dr. Dennis both find lesions and some fibrosis. Dr. Caffrey did opine that because the complicated workers' pneumoconiosis only comprised 5% of the miner's lungs, it was minimal, did not cause the miner any health problems, and did not cause, contribute, or hasten the miner's death. Dr. Perper concluded that the coal workers' pneumoconiosis and the associated centrilobular emphysema was a substantial contributory cause of the miner's death, both directly and indirectly.

Dr. Fino's conclusion as to whether pneumoconiosis hastened the miner's death is equivocal. His conclusion that cardiac arrhythmia was the most likely cause is not conclusive. An opinion may be given little weight if it is equivocal or vague. ***Island Creek Coal Co. v. Holdman***, 202 F.3d 873 (6th Cir. 2000). In this case his conclusion is not vague but it is equivocal.

Dr. Rosenberg indicates that the miner died from myocardial infarction, and that the miner's simple pneumoconiosis was of a mild nature, not sufficiently extensive to hasten, contribute to, or cause death. Dr. Caffrey similarly concluded that because coal workers'

[15] Jimmy Maggard, the Kentucky Coroner, was deposed and questioned concerning the reasons for amending the death certificate from a conclusion that myocardial infarction caused the miner's death to the amended certificate, which now has listed pneumoconiosis as the immediate cause of death. It should be noted that Mr. Maggard's deposition was taken and admitted into the record. However, the Employer's Counsel did not designate this evidence for consideration in this survivor's claim and; therefore, any discussion regarding the reasons for the change in causation is outside the permissible scope of evidence.

pneumoconiosis occupied only 5% of the miner's lung tissue, it was mild and did not result in impairment. The miner's death was not hastened by pneumoconiosis. Dr. Caffrey explicitly stated that the autopsy slides did not reveal evidence of myocardial infarction, but qualified his conclusion by stating that had the miner lived long enough such evidence may have been demonstrated on the autopsy slides. Dr. Caffrey found subpleural anthracotic pigment and associated fibrosis. Dr. Caffrey does not adequately explain why these findings, along with the miner's extensive coal mine employment history are not factors in hastening, contributing, or causing the miner's death. The Sixth Circuit reaffirmed its holding in Brown to state that benefits are awarded to a survivor who establishes that "pneumoconiosis is a substantially contributing cause or factor leading to the miner's death if it serves to hasten that death in any way." *See* ***Griffith v. Director, OWCP***, 49 F.3d 184 (6th Cir. 1995).

Both Dr. Perper and Dr. Dennis conclude that the evidence revealing black pigment deposits along with fibrosis indicate the presence of pneumoconiosis. Dr. Perper found areas of solid fibrosis within the miner's lungs. Both Doctors conclude that pneumoconiosis contributed to the demise of the miner and hastened the miner's death. The miner's extensive history of coal mine dust exposure, along with the presence of coal workers' pneumoconiosis and centrilobular emphysema were all factors contributing to the miner's death.

In the absence of complicated pneumoconiosis, the burden is on the Claimant to put forth sufficient evidence to establish that the miner's death was due to pneumoconiosis. The Employer is not obligated to prove a negative, but in response to positive affirmative evidence sufficient to establish death to pneumoconiosis, the Employer *must* proffer evidence to rebut the Claimant's evidence. I conclude that the Employer has failed to rebut the evidence presented by Drs. Perper and Dennis, successfully establishing that the presence of coal workers' pneumoconiosis hastened the miner's death beyond a negligible degree. I also note that this is not a situation where there is conflicting, but equally probative evidence, for and against, the determination that pneumoconiosis hastened the miner's death.

I conclude that the Claimant has established that pneumoconiosis hastened the miner's death.

CONCLUSION

The Claimant has successfully established the presence of pneumconiosis, that pneumoconiosis is due to coal mine employment, and that the miner's death was due to pneumoconiosis. Therefore, find that the Claimant has demonstrated all of the elements required for entitlement to benefits under the Black Lung Benefits Act.

If the claimant is an eligible survivor of a miner entitled to benefits under the Act, benefits may be paid beginning with the month of the miner's death. 20 C.F.R. §725.503(c) (2000) and (2001). The miner died in December 2001. The Claimant is, therefore, entitled to benefits beginning in the month of December 2001.

ORDER

It is hereby **ORDERED** that the claim of **I.C.** be **GRANTED**. It is furthered ordered that the Employer, **Kentucky May Coal Co.**, shall pay to the Claimant all benefits to which she is entitled under the Act commencing December 1, 2001, the month in which he passed away.

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DANIEL F. SOLOMON
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.478 and 725.479. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481. If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).